DOCUMENT RESUME

ED 439 542 EC 307 721

TITLE	Medicaid and Special Education: Coordination of Services for Children with Disabilities Is Evolving.
INSTITUTION	General Accounting Office, Washington, DC.
REPORT NO	GAO/HEHS-00-20
PUB DATE	1999-12-00
NOTE	27p.
AVAILABLE FROM	U.S. General Accounting Office, P.O. Box 37050, Washington, DC 20013 (first copy free, additional copies $2, 100 copies or more to a single address discounted 25 percent). Tel: 202-512-6000; Tel: 202-512-2537 (TDD); Fax: 202-512-6061; Web site: http://www.gao.gov.
PUB TYPE	Reports - Evaluative (142)
EDRS PRICE	MF01/PC02 Plus Postage.
DESCRIPTORS	*Agency Cooperation; Coordination; Delivery Systems; *Disabilities; Elementary Education; Federal Legislation; Federal State Relationship; *Financial Support; Guidelines; *Medical Services; Privacy; Program Evaluation; School Districts; *Shared Resources and Services
IDENTIFIERS	Individuals with Disabilities Education Act; *Medicaid

ABSTRACT

This report discusses the results of an investigation into the coordination between the Individuals with Disabilities Education Act (IDEA) and the Medicaid program. Interagency agreements and other documentation were obtained and analyzed from 12 state directors of special education, coordination mechanisms reported by key federal agencies were analyzed, and coordination in five urban school districts was reviewed. Results indicate Medicaid and IDEA interact differently at the federal, state, and local levels and the extent and nature of coordination continue to evolve. For the 12 states, interagency agreements and agency liaisons are the primary mechanisms of state-level interaction between Medicaid and IDEA. Interagency agreements are generally used to assign roles and responsibilities to participating agencies, while agency liaisons typically serve as resources for coordination efforts. Local interactions between Medicaid and IDEA are affected by a variety of factors, including the commitment of individual school districts to seek Medicaid reimbursement. Efforts to coordinate Medicaid and IDEA have been adversely affected by the need to safeguard the privacy of children with disabilities while ensuring appropriate documentation for claiming Medicaid reimbursement and by the lack of clear and consistent federal guidance. The development of additional guidance by the Health Care Financing Administration is discussed. (CR)

Reproductions supplied by EDRS are the best that can be made
from the original document.

United States General Accounting Office

GAO

Report to the Honorable Edolphus Towns, House of Representatives

December 1999

MEDICAID AND SPECIAL EDUCATION

Coordination of Services for Children With Disabilities Is Evolving

ED 439 542

U.S. DEPARTMENT OF EDUCATION
NATIONAL INSTITUTE OF EDUCATION
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)
☑ This document has been reproduced as received from the person or organization originating it.
☐ Minor changes have been made to improve reproduction quality.
• Points of view or opinions stated in this document do not necessarily represent official NIE position or policy.

BEST COPY AVAILABLE

G A O

Accountability • Integrity • Reliability

GAO/HEHS-00-20

2

GAO

United States
General Accounting Office
Washington, D.C. 20548

Health, Education, and
Human Services Division

B-283771

December 10, 1999

The Honorable Edolphus Towns
House of Representatives

Dear Mr. Towns:

The Individuals With Disabilities Education Act (IDEA) and Medicaid have the potential to offer children with disabilities a variety of services and equipment that can be critical to their educational development and physical well-being. Providing $4.3 billion in fiscal year 1999, part B of IDEA, the Assistance to States for the Education of Children With Disabilities program, assists school districts in meeting their obligation to make available to all students with disabilities special education and related services that are necessary for these students to benefit from special education. Some of the costs of related services provided to low-income children under IDEA may be covered by Medicaid, a federal/state program that spent about $177 billion in fiscal year 1998 to provide medical care for certain categories of low-income Americans, including approximately 17 million children.[1] Although Medicaid traditionally is the payer of last resort for health care services, since 1988 Medicaid has been required to reimburse for IDEA-related medically necessary services for eligible children before any IDEA funds are used.[2]

IDEA's authorizing legislation and regulations require that it coordinate with other federal programs, such as Medicaid, to finance and deliver services to children with disabilities. However, because the boundaries of operation for IDEA and Medicaid are somewhat unclear, concerns have arisen regarding the mechanisms of coordination between these two programs. Accordingly, you asked us to (1) describe how Medicaid and IDEA interact to meet the needs of low-income school-aged children with disabilities and (2) identify issues that have arisen in coordinating Medicaid and IDEA services in schools.

To accomplish this, we contacted selected federal and state officials, as well as a small number of local school district officials, regarding the coordination mechanisms employed by IDEA that are relevant to Medicaid activities in schools. To review federal efforts at coordination, we

[1]Because 1998 statistics on children are not yet available, our figure for the number of children receiving medical care covered by Medicaid is based on fiscal year 1997 data.

[2]The Medicare Catastrophic Coverage Act of 1988 enacted this requirement, which is currently codified at 42 U.S.C. 1396b(c).

BEST COPY AVAILABLE

contacted the Department of Health and Human Services' (HHS) Health Care Financing Administration (HCFA), which has oversight responsibility for the Medicaid program, and Department of Education staff involved in coordinating IDEA with Medicaid.[3] For the state perspective, we contacted 12 states: 9 that were among the states with the highest number of school-aged children in special education and 3 that had predominantly rural populations.[4] We obtained and analyzed the content of interagency agreements and other documentation from selected state directors of special education. We also contacted Education's northeast and southeast Regional Resource Centers, which are funded by the Office of Special Education Programs and provide technical assistance to state education agencies. We analyzed the coordination mechanisms reported by the federal agencies; 12 states; and five urban school districts, which varied in size from 3,000 to 156,000. We conducted our work between September and October 1999 in accordance with generally accepted government auditing standards.

Results in Brief

Medicaid and IDEA interact differently at the federal, state, and local levels, and the extent and nature of coordination continue to evolve. Federal efforts focus on (1) helping states access funding sources such as Medicaid and (2) working to develop clear and consistent guidance to help educational entities appropriately claim Medicaid funding for IDEA-related medical services. While charged with ensuring that Medicaid-eligible individuals have access to and receive covered services, HCFA must also safeguard Medicaid against improper claims. For the 12 states we contacted, interagency agreements and agency liaisons are the primary mechanisms of state-level interaction between Medicaid and IDEA. Interagency agreements are generally used to assign roles and responsibilities to participating agencies, while agency liaisons typically serve as resources for school districts' coordination efforts. Local interactions between Medicaid and IDEA are affected by a variety of factors, including the commitment of individual school districts to seek Medicaid reimbursement, as well as specific characteristics and concerns of local communities.

As states and school districts have worked to obtain Medicaid reimbursement for covered school-based services, several concerns

[3]Although IDEA also offers coverage for infants and toddlers (under part C of the statute), our review focuses only on school-aged children receiving IDEA services under part B.

[4]We contacted Florida, Illinois, Maine, Massachusetts, Michigan, New Jersey, New York, Ohio, Pennsylvania, South Dakota, Texas, and Vermont. Collectively, these 12 states accounted for 43 percent of fiscal year 1996-97 Grants to States, IDEA part B, funds and 47 percent of federal Medicaid funds in 1998.

regarding coordination with IDEA have arisen. In the 12 states we contacted, coordination concerns generally revolve around determining which IDEA-related services Medicaid will cover, identifying children who are eligible for both programs, and managing the documentation required for submitting Medicaid claims. These efforts are complex for many reasons, including the need to safeguard the privacy of children with disabilities while ensuring appropriate documentation for claiming Medicaid reimbursement. Efforts to coordinate Medicaid and IDEA have also been affected by the lack of clear and consistent federal guidance. Six of the 12 directors of special education and three of the five local school district representatives with whom we spoke reported concerns about Medicaid as a consistent source of funding. That is, inconsistent guidance from HCFA appears to have heightened school district concerns that Medicaid reimbursements will have to be returned to the federal government later because of inappropriate documentation or changes in documentation requirements. Recognizing the need for better coordination, HCFA is developing additional guidance, which it plans to issue in 2000. Additionally, HCFA has established a position to advise its Administrator on disability policy and to facilitate communication among the Administrator of HCFA; other federal policymakers, including the Assistant Secretary for Special Education and Rehabilitation Services; and the disability community. While these actions will not solve the difficulties in coordinating Medicaid and IDEA services, state and local efforts could be facilitated by federal guidance in communicating Medicaid's coverage and documentation requirements.

Background

Medicaid is a joint federal-state program that annually finances health care coverage for more than 40 million low-income individuals, one-half of whom are children. States operate their programs within broad federal requirements and can elect to cover a range of optional populations and services. As a result, Medicaid essentially operates as 56 separate programs: one in each of the 50 states, the District of Columbia, Puerto Rico, and the U.S. territories. Medicaid is an entitlement program; hence, states and the federal government are obligated to pay for all covered services provided to an eligible individual.

Generally, the federal government shares in states' Medicaid costs that fall under two categories: medical assistance and administrative activities. For medical assistance payments, each program's federal and state funding shares are determined through a statutory matching formula. This formula results in federal shares that range from 50 to 83 percent, depending on

each state's per capita income in relationship to the national average. For administrative claims, the federal share varies by the type of costs incurred. Most administrative expenditures are matched at a fixed rate of 50 percent, making the federal government's contribution equal to that of a state. However, certain administrative expenditures are matched at a rate higher than 50 percent.[5] Most Medicaid expenditures are for medical assistance payments: over 95 percent of Medicaid's $177 billion in total expenditures in fiscal year 1998 was for health services.

Schools' practices for filing claims for Medicaid reimbursement of covered services for eligible children vary, depending on whether a school is seeking reimbursement for health services, administrative activities, or both. Schools that claim Medicaid for health services must meet the Medicaid provider qualifications established by each state. In order to be eligible for payment, all providers must meet the requirements established by the state and have a provider agreement with the state Medicaid agency. Schools may also receive reimbursement for administrative activities that are found to be necessary for the proper and efficient administration of a Medicaid state plan. Such activities may include Medicaid outreach, application assistance, information dissemination, referral for services, coordination and monitoring of health services, and interagency coordination.

Schools can be an appropriate location from which to identify, enroll, and provide Medicaid services to low-income children. In addition to services offered in hospitals, clinics, or other health care locations, states are authorized to use their Medicaid programs to help pay for certain health care services delivered to Medicaid-eligible children in a school-based setting. In some cases, states have identified schools as providers of Medicaid services. The amount and type of services provided in school-based settings vary by state, ranging from services provided by contractors who visit the schools to services offered by fully equipped school-based health clinics with permanent staff. Commonly provided school-based services that qualify for federal funds include physical, occupational, and speech therapy as well as diagnostic, preventive, and rehabilitative services.

Finally, providing Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services to all Medicaid-enrolled children under 21 years of age offers eligible children with or without disabilities a special entitlement to

[5]For example, the cost of developing automated systems is federally matched at a 90-percent rate, and the cost of activities performed by skilled professional medical personnel can, under certain conditions, be matched at a 75-percent rate.

health care. Under EPSDT, states are required to cover any service or item that is medically necessary to correct or ameliorate a condition detected through an EPSDT screening, regardless of whether the service or item is otherwise covered under a state Medicaid program. States must also conduct activities to inform Medicaid-eligible individuals about the EPSDT benefit and encourage their participation in the Medicaid program. For instance, states are required to provide Medicaid-eligible children and families with assistance in locating EPSDT health care providers, assistance in scheduling medical appointments, and transportation. Hence, under EPSDT, Medicaid-eligible children have a broad entitlement to medically necessary services.

Federal assistance to states under IDEA is contingent on the states' obligation to make available to all children with disabilities a free, appropriate public education. School districts are obligated to provide a free, appropriate public education whether or not they receive federal funds. In fiscal year 1999, the IDEA Grants to States program provided $4.3 billion in federal funds and served 6.1 million children.[6] Funding is based on a child count formula that allocates aid to states on the basis of the number of children with disabilities receiving special education and related services. Although the formula authorizes a maximum federal allotment for each child with a disability who is served that is 40 percent of the national average per pupil expenditure for special education, the fiscal year 1999 figure of $4.3 billion actually represents 11.7 percent of this average expenditure.[7] The act specifies several procedures that school districts must follow in providing educational services to children with disabilities.

Under IDEA, local school districts, through the schools, must determine whether a child has a disability and what the educational needs of the child are. For each child with a disability, the school must

- develop, in conjunction with the child's parents, teachers, and others, an individualized education program (IEP), which is a written statement that

[6]IDEA's total federal appropriation for fiscal year 1999 was $5.3 billion, $4.1 billion of which was for Grants to States under part B; $0.2 billion was an advance from prior year funding for part B. Additional IDEA funding included $374 million for the Preschool Grants program; $370 million for the Grants for Infants and Families program; as well as resources for IDEA national programs, which fund, among other things, state program improvement grants and parent information centers.

[7]The IDEA Amendments of 1997 (P.L. 105-17) provide for the formula to change to one that is population-based once the appropriation for the program exceeds $4.9 billion.

BEST COPY AVAILABLE

details the education and supportive services a student with a disability will receive;[8]
- provide services in accordance with the IEP;
- review each child's IEP at least annually and revise it as appropriate; and
- reevaluate the child's need for special education services as appropriate, but at least once every 3 years.[9]

In addition to requiring special education services, IDEA also obligates a school district to provide the "related services" that are required to help a child with disabilities to benefit from special education, including transportation, speech-language pathology and audiology services, psychological services, physical and occupational therapy, social work services, counseling, and medical services.[10] Similarly, assistive technology (such as special computer software or a device to assist in holding a pencil) may be needed to help the student participate in school. Furthermore, IDEA services are not limited to being delivered in a school-based setting but can also be provided in homes, hospitals, corrective facilities, or other locations if necessary in order for the child to receive a free, appropriate public education.

Recognizing the breadth of services that can be provided—many of which may be covered by Medicaid or other programs—IDEA requires that educational entities perform several activities that are aimed at coordinating IDEA services with the services of other agencies. In particular, IDEA requires the following activities:

- The state must have in effect policies and procedures to ensure the identification, location, and evaluation of all children with disabilities who are in need of special education and related services ("child find").[11] Each agency participating in child find must be identified and the nature and extent of its participation documented.

[8]The IDEA regulations specify that the IEP team must include (1) parent(s); (2) at least one of the child's regular education teachers (if the child is, or may be, participating in the regular education environment); (3) one of the child's special education teachers; (4) a representative of the public agency involved; (5) an individual to interpret the implications of evaluation results; (6) the child (when appropriate); and (7) other individuals with knowledge or special expertise regarding the child. See "Assistance to States for the Education of Children With Disabilities and the Early Intervention Program for Infants and Toddlers With Disabilities," final regulations, 64 Fed. Reg. 12,405, 12,440 (1999) (to be codified at 34 C.F.R. 300.344).

[9]See 42 U.S.C. 1414.

[10]In this context, related services that are defined as medical are limited to those for diagnostic or evaluation purposes.

[11]See "Assistance to States," 64 Fed. Reg. 12,405, 12,427 (1999) (to be codified at 34 C.F.R. 300.125(a)(i)).

BEST COPY AVAILABLE

- The state must also establish responsibility for providing services, which involves developing an interagency agreement or other mechanism for coordination.[12] The agreement or mechanism must address (1) agencies' financial responsibilities, (2) conditions and terms of reimbursement, (3) procedures for resolving interagency disputes, and (4) policies and procedures for coordinating services.

Finally, for any fiscal year, IDEA allows school districts to use up to 5 percent of the amount received under part B (Grants to States) in combination with other amounts to develop and implement a coordinated service system designed to improve results for children and families.[13] Funding is expected to include funds other than for education, and Medicaid is cited as one of several federal and state programs for which service coordination and case management activities would be appropriate.

Medicaid can be an important source of funding for schools, particularly because the costs of providing special education can greatly exceed the federal assistance provided under IDEA. Children who qualify for IDEA are frequently eligible for Medicaid services, and although Medicaid is traditionally the payer of last resort for health care services, it is required to reimburse for IDEA-related medically necessary services for eligible children before IDEA funds are used.[14] Because many services required by a child's IEP are health-related or medical in nature, the Medicaid entitlement is an attractive option for funding many IDEA services for low-income children with disabilities. Furthermore, some administrative activities under Medicaid, such as EPSDT outreach, can be relevant for such IDEA activities as child find. Hence, educational entities have both programmatic and financial incentives to ensure that coordination exists between Medicaid and IDEA.

Additionally, concerns regarding the costs of implementing IDEA and the need to identify alternative sources of funding have heightened as a result of a recent Supreme Court case. In Cedar Rapids Community School District v. Garret F.,[15] the Supreme Court held that under IDEA, the school district must provide the student with the nursing services he requires

[12]See "Assistance to States," 64 Fed. Reg. 12,405, 12,429 (1999) (to be codified at 34 C.F.R. 300.142(a)).

[13]See "Assistance to States," 64 Fed. Reg. 12,405, 12,435 (1999) (to be codified at 34 C.F.R. 300.244(a)).

[14]34 C.F.R. 300.442 (a)(1).

[15]Cedar Rapids Community School District v. Garret F., 526 U.S. 66 (1999).

BEST COPY AVAILABLE

during school hours.[16] The superintendent of the Cedar Rapids Community School District and the National School Board Association have expressed concern about the financial obligations that may be associated with this decision; others disagree, stating that the decision did not add financial obligations or requirements beyond those already in effect. While not adding new Medicaid requirements, the Court's decision does have relevance for Medicaid costs to the extent that states provide services through IDEA that are eligible for Medicaid payment.

Medicaid and IDEA Interactions Vary Across Levels of Government

Medicaid and IDEA interact differently at the various levels of government: federal, state, and local. At the federal level, interactions center around (1) assisting states with accessing funding sources such as Medicaid and (2) providing guidance so that educational entities can appropriately claim Medicaid for IDEA-related medical services. While charged with ensuring that Medicaid-eligible individuals have access to and receive covered services, HCFA must also safeguard the use of Medicaid funds to ensure their appropriate use. For the 12 states we contacted, interagency agreements and agency liaisons at the state and, occasionally, local levels are the key mechanisms of interaction between Medicaid and IDEA. In addition to the state-specific coverage criteria for state Medicaid programs, local interactions between Medicaid and IDEA are affected by a variety of factors, including the individual commitments of school districts to seek Medicaid reimbursement and specific characteristics and concerns that exist within a school district or local community.

Federal Interactions Between Medicaid and IDEA Reflect Differing Agency Roles

Federal interactions between Medicaid and IDEA reflect the different roles of HCFA and the Department of Education. While acknowledging the importance of covering the school-based service needs of Medicaid-eligible children, HCFA officials we spoke with expressed concerns about the appropriateness of certain billing practices in schools. In particular, school districts' claims for administrative costs associated with school-based health services have increased fivefold over the past 4 years, and federal oversight of school districts' claims has been weak. Thus, an environment conducive to opportunism has developed in which

[16]Recognizing that the school district must fund "related services" to integrate such students into the public schools, the Court looked to the "bright line" test established in Irving Independent School District v. Tatro, 468 U.S. 883 (1984). Under this test, the services of a physician (other than for diagnostic and evaluation purposes) are subject to the medical services exclusion, but services that can be provided in the school setting by a nurse or qualified layperson are not. Therefore, while the Court in Garret F. acknowledged the student's need for more extensive services, it noted that such services are no more "medical" than the care sought in Tatro and must be provided by the school district as "related services."

BEST COPY AVAILABLE

inappropriate claims have the potential for generating excessive Medicaid payments.[17] Recognizing that states and schools have a strong incentive to maximize federal dollars, HCFA has focused its recent efforts to maintain the integrity of the Medicaid program on working to develop and disseminate guidance for schools and states. To support these efforts, HCFA has instituted work groups aimed at clarifying appropriate billing practices for IDEA-related services in schools.

In contrast to Medicaid, which has no statutory requirements for coordinating services and activities with educational entities, IDEA's statutory mandate requires that educational agencies bear the responsibility for coordinating IDEA-related services with other agencies, such as Medicaid. Moreover, limited funds and the broad array of services that IDEA can cover make finding additional funding sources important. Education's chief coordination efforts have been aimed at helping states obtain funding through such sources as Medicaid. Education's coordination with HCFA has slowly increased over time. Education officials told us they were not involved initially in HCFA's work groups or in developing guidance disseminated by HCFA in the spring of 1999 regarding Medicaid billing practices in schools.[18] More recently, Education officials indicated that they have participated in one work group and stressed that coordination with HCFA is extremely important to fostering coordination between Medicaid and IDEA at the state level.

State Interactions Between Medicaid and IDEA Take Place Primarily Through Interagency Agreements and Agency Liaisons

State-level interactions between Medicaid and IDEA for the 12 states we contacted are primarily governed through two mechanisms: interagency agreements and agency liaisons. All states we contacted said that they had, as required under IDEA, either an interagency agreement or other mechanisms for coordinating with Medicaid. Interagency agreements in 10 states serve as mechanisms for outlining the responsibilities of the education and Medicaid agencies. Some states have included additional provisions in their agreements aimed at simplifying coordination, providing quality review, or both. All 12 states identified agency liaisons that are responsible for coordinating Medicaid claims for school-based services. While the responsibilities of these liaisons—and their location within state government—vary across states, liaisons are generally

[17]See Medicaid: Questionable Practices Boost Federal Payments for School-Based Services (GAO/T-HEHS-99-148, June 17, 1999).

[18]On May 21, 1999, HCFA sent a letter to state Medicaid directors regarding reimbursement for school-based health services under Medicaid. This letter explained practices associated with reimbursement for transportation and reported efforts under way to review state practices for claiming reimbursement for school-based health-related administrative activities.

BEST COPY AVAILABLE

expected to serve as resources and to assist in resolving problems with coordinating the two programs.

Interagency Agreements Outline Responsibilities of Medicaid and Education Agencies

The language and terms of the interagency agreements we reviewed range from general to more specific descriptions of each agency's role. While some aspects of the agreements vary, they focus primarily on assigning roles to the Medicaid agency, the education department, and other key stakeholders. For example, the general responsibilities of the Medicaid agencies include performing fiscal duties, determining eligibility, and reviewing and processing claims. Similarly, the education agencies are responsible for screening children for Medicaid eligibility, facilitating the Medicaid application process, and maintaining student records.

Some states have included additional provisions in their agreements to enhance coordination efforts. For example, Pennsylvania's agreement includes both individual and mutual activities for the Medicaid and education agencies for outreach, education, care coordination, service site development, and monitoring and evaluation. In Texas, the agencies jointly agreed to coordinate products and activities for the school districts and to provide ongoing training and workshops within and between the two agencies. Vermont prepared a section on school health services for its Medicaid Practices and Procedures Manual, which details the guidelines for program management, reimbursement, and fiscal monitoring, including audit control and corrective action plans.

To ensure quality and maximize services, several states have included requirements for maintaining a system of checks and balances. In Illinois, the Medicaid agency reviews the data submitted from the local education agencies, including the eligibility status of the recipient, the certification of the provider, and the codes for covered services. Michigan's process of quality assurance involves both its Education and Medicaid agencies. Although Michigan's Education Department is responsible for performing compliance audits, it sometimes conducts joint audits with the state's Medicaid agency. Education is responsible for submitting the results of the on-site review of records and other essential documents to the state Medicaid agency, while Medicaid verifies the methodology for payments.

Agency Liaisons Serve as Resources for School Districts

The 12 states we contacted identified agency liaisons that are responsible for coordinating Medicaid and school-based services. Over half of these states have designated liaisons in both education and Medicaid agencies. For example, while Florida has a liaison in the Department of Education, the state also has 11 Medicaid program specialists who act as school

liaisons by assisting in coordination efforts. These specialists work for the Medicaid Area Program offices that administer Florida's Medicaid program.

Agency liaisons also serve as general resources and problem solvers for school districts. Officials in Ohio's Department of Education consider themselves a resource for local education agencies because they answer questions about Medicaid and the billing certification procedure. Illinois state agency officials reported that the state's most important coordination mechanism has been the identification of an agency liaison, which was instrumental in solving a problem the state faced in reconciling medical and education terminology. In some instances, the responsibilities of the liaisons vary to meet the needs of a state's unique Medicaid program and school systems. For example, New York has 11 coordinators in regional information centers who help school districts and counties use their software to create billing systems, collect data from schools, and set up training sessions. In addition, the state has other education liaisons who focus on Medicaid claims processing.

Varying Characteristics of Localities Often Shape Interactions

Just as state Medicaid programs are unique in their design and implementation, the approximately 15,000 U.S. school districts also vary greatly in size and scope. For example, in the 1995-96 school year, 23 districts had enrollments of over 100,000 students, while a much larger number of districts reported serving fewer than 150 students. In our previous work on school districts' implementation of federal requirements, we found that district officials often lacked accurate, timely, and detailed information on federal programs and requirements, particularly for complex programs such as IDEA and Medicaid.[19] In addition, districts can have different levels of experience and expertise in claiming federal funds from programs such as Medicaid.

School districts also have different levels of commitment to claiming Medicaid funds. For example, state agency officials in Michigan and Florida informed us that they have been given a clear mandate to encourage school districts' use of Medicaid for school-based services and to carry out whatever coordination tasks are necessary to ensure participation. Michigan schools have been encouraged by the state Education Department to become Medicaid providers. In Florida, the state has passed legislation aimed at billing Medicaid for direct services in the

[19]See Elementary and Secondary Education: Flexibility Initiatives Do Not Address Districts' Key Concerns About Federal Requirements (GAO/HEHS-98-232, Sept. 30, 1998).

BEST COPY AVAILABLE

schools; before this legislation, interactions between Medicaid and education at the state level were limited to case-by-case instances. Even with a clear mandate to use Medicaid for school-based services, however, individual school districts vary in their approach to claiming Medicaid. For example, one school district in Florida started with a pilot program to bill Medicaid and slowly expanded its efforts over time, an approach that district officials characterized as very conservative, compared with that of another school district in the state.

Finally, school districts may have specific concerns that are shaped by local circumstances. While these circumstances may not be restricted solely to coordination issues between Medicaid and IDEA, they nonetheless affect the districts' ability to provide and fund appropriate services to children with disabilities.

- Some providers and the services they offer are either unavailable or in short supply in some communities.[20] In particular, shortages of such services as early intervention, transportation, and medical services are more pronounced in rural than in other areas. Some rural districts may also have difficulties locating providers of certain related services, such as physical therapy and speech pathology, according to district and state officials.
- Officials from one school district in Vermont reported that the difficulty in reading that some parents of children with disabilities have makes it difficult for them to learn about Medicaid. When such concerns are suspected, school personnel make personal contact with the parents, informing them about Medicaid and assisting them in completing the enrollment form.
- Under IDEA, after the IEP is developed, the school district must provide the agreed-upon services "within a reasonable period of time," usually 60 days. District officials may not receive reimbursement—or know for sure that reimbursement will be allowed—within this time period.

Implementation Efforts Reflect Attempts to Address Coordination Issues

State and local efforts to seek Medicaid reimbursement for covered school-based services reveal several coordination issues between Medicaid and IDEA. In the 12 states we contacted, these issues generally revolve around achieving clarity (and sometimes consensus) on what services Medicaid will pay for, determining Medicaid eligibility for children with IEPs, and establishing clear methods of documentation for

[20]See SSI Children: Multiple Factors Affect Families' Costs for Disability-Related Services (GAO/HEHS-99-99, June 28, 1999).

billing Medicaid. States' approaches to addressing these issues vary. Coordinating these activities between educational entities and Medicaid programs has been hampered by the lack of clear and consistent federal guidance regarding the proper billing procedures for Medicaid. Six of the 12 directors of special education and three of the five local school district representatives with whom we spoke expressed concerns about Medicaid as a consistent source of funding. Some state officials also specifically mentioned waiting for HCFA to issue guidance on claiming Medicaid for school-based services and administrative activities, which is expected to occur sometime in the year 2000.

State and Local Efforts Reflect Similar Concerns; Approaches to Resolving Them Vary

States and local school districts cited similar coordination concerns about coverage, or identifying Medicaid-reimbursable services; eligibility, or how to identify children who are, or should be, enrolled in Medicaid; and documentation, or compiling service data, submitting claims, and receiving reimbursement from Medicaid.

Coverage

State and local officials we contacted often reported difficulties distinguishing between medical and educational activities and, thus, clearly identifying which IDEA-related services Medicaid can be expected to cover. For example, state education officials in New York, Massachusetts, and Florida reported that it is frequently unclear whether speech and language therapy are medical (rehabilitative) or educational (developmental) in nature. Occupational therapy, such as fine motor coordination or handwriting therapy, was also offered as an example of a service that may or may not qualify for Medicaid coverage.

The uncertainty over what Medicaid will cover is exacerbated by differences in terminology for educational and medical services. For example, what education officials term an "intervention" can be called "suicide prevention" or "crisis services" by the medical world. A second example is the nature and characterization of counseling services, which schools are likely to call "behavioral programming or management" and Medicaid may term "therapy."

Additionally, coordinating the differing requirements of Medicaid and IDEA can be challenging. For example, required qualifications for Medicaid providers may be higher than the standards of local school districts, thus limiting the reimbursement that can be obtained under Medicaid. For instance, in Maine, Medicaid requires licensure for speech/language pathologists, a higher standard than the certification that schools require.

One state education official told us that Maine is currently attempting to pursue licensure for all speech/language pathologists so that schools can receive Medicaid reimbursement for this service. A second issue involving differing program requirements that is echoed by state and local officials is the inherent conflict between Medicaid's need for a diagnosis and a school's preference to discuss a child's needs and develop an IEP without specifically labeling the child. In one Florida school district, local officials told us they have resolved this issue by having the school therapist contact the child's primary care physician, who then identifies the appropriate diagnostic code(s).

These challenges at the state and local levels have not gone unrecognized by federal agencies. Staff from both HCFA's regional offices and Education's Regional Resource Centers acknowledge the difficulties in distinguishing between medical and educational services. For example, HCFA officials noted that the medical and educational components of certain activities, such as physical and occupational therapy, case management, and behavioral services, are difficult to separate. Moreover, the long-term nature of some school-based health services (such as occupational or physical therapy) runs counter to Medicaid's more traditional service delivery, which often involves short-term rehabilitative services following surgery or an accident.

Eligibility

Identifying children who are Medicaid-eligible—whether enrolled or not—is a critical task for schools interested in claiming Medicaid funding for IDEA-related services. In addition to the difficulties faced in identifying children who are eligible but not enrolled in Medicaid,[21] schools do not always have ready access to information regarding children already enrolled in Medicaid. A New York official reported that ensuring confidentiality—that is, identifying IDEA children who are also Medicaid-eligible without disclosing medical or educational information—was initially one of the biggest challenges to coordinating Medicaid and IDEA. Federal law prohibits issuing the names of individuals with disabilities to any noneducational agency without parental consent, thus making it difficult for schools to match names of children receiving IEP services with names of Medicaid enrollees.[22] In light of this requirement, New York developed a system under which its Department of Health provides a list of Medicaid-eligible children to the Department of

[21]See Medicaid: Demographics of Nonenrolled Children Suggest State Outreach Strategies (GAO/HEHS-98-93, Mar. 1998).

[22]See 42 U.S.C. 1232g(b)(1).

Education for the purpose of performing matches.[23] Three other states—Illinois, Michigan, and Texas—also reported using a tape match to identify IDEA children who are Medicaid-eligible. A Pennsylvania official indicated that, while the state has been interested in a tape match, it is still working to establish a method that is acceptable to state and HCFA officials.

Another challenge faced by some states in determining Medicaid eligibility centers on the concept of third-party liability (TPL) [24] under the Medicaid statute.[25] Medicaid rules generally require that Medicaid pay for services only after TPL sources have met their legal obligation to pay, while IDEA legislation requires that parents not be charged for services provided through an IEP.[26] Reconciling these statutory requirements for purposes of determining Medicaid eligibility is a coordination challenge that states have addressed in different ways.[27]

- In Pennsylvania, an official explained that students' claims for reimbursement for services must first be rejected by their private insurance company before Medicaid can be billed, a requirement that delays the reimbursement process.
- South Dakota state agency officials stated that the schools ask parents whether the child has third-party insurance. If the child's parents have an outside source of insurance and refuse to authorize its use, Medicaid cannot be billed, leaving the school obligated to cover the cost.
- In New York, the state Department of Health contacts insurance companies on behalf of the school districts and identifies the services that

[23]In this process, New York's Department of Health provides only the names, dates of birth,and sex of the children eligible for Medicaid to comply with the privacy laws applicable to the Medicaid program.

[24]TPL refers to the legal obligation of certain health care payers (including private health insurance, Medicare, employment-related health insurance, and noncustodial parents providing medical support) to pay the medical claims of Medicaid beneficiaries before Medicaid pays these claims.

[25]See 42 U.S.C. 1396a(a)(25).

[26]IDEA part B funds may be used to pay deductible or copayment amounts that would be incurred under private or public insurance. See "Assistance to States," 64 Fed. Reg. 12,405, 12,430 (1999) (to be codified at 34 C.F.R. 300.142(e)(2)(ii) and 34 C.F.R. 300.142(g)(2)). In the event that state Medicaid programs have cost-sharing requirements, such as copayments, IDEA-related services must be provided free of charge to children. Since traditional Medicaid does not allow cost sharing for services provided to most children, such cases are likely to be limited to states with Medicaid demonstration waivers under which innovative approaches to Medicaid, such as cost sharing, are tested.

[27]Medicaid regulations at 42 C.F.R. 433.139 specify that, in general, if probable TPL is established at the time a claim is filed, the state Medicaid agency must reject the claim and return it to the provider for a determination of the amount of liability. However, if probable liability is not established or benefits are not available at the time the claim is filed, the Medicaid agency must pay the full amount allowed under the payment schedule. The Medicaid agency must then seek reimbursement from the liable party unless it determines the recovery would not be cost-effective.

BEST COPY AVAILABLE

schools provide. The insurance companies are then asked to identify services they will cover in a letter to the New York Department of Health. These letters are used to document that TPL recovery does not apply to the children covered under these policies. While the New York official who described this process indicated that it works, he mentioned that it is very cumbersome and requires considerable staff resources.

Documentation

Medicaid documentation requirements are more burdensome than those of IDEA, leading states to cite this as an area of concern in coordinating Medicaid and IDEA services. State agency officials from Florida, New York, Ohio, Pennsylvania, and Texas cited documentation as a challenge that, in some instances, discourages school districts from filing claims for Medicaid reimbursement. In light of documentation concerns, a few states have adopted procedures to ease the process for school districts while still meeting the documentation requirements of Medicaid.

- Two states, Vermont and Massachusetts, identified bundled rates as a convenient means of reducing documentation. Bundling rates for purposes of billing Medicaid is an approach that combines rates for several Medicaid-covered school-based services into a single statewide rate. Hence, rather than submitting claims for each service provided to a child—for example, three claims for a child who receives physical therapy, occupational therapy, and psychological services—a school may file one claim to receive compensation for all three services. Vermont state and local school district officials contend that although bundling reduces the overall amount of paperwork, documentation requirements established by Medicaid are still satisfied. One Massachusetts education agency official reported that the less intensive paperwork involved in bundling rates has made it easier for smaller schools to participate in claiming Medicaid reimbursement.[28]
- One school district in Florida consolidated information on education-related forms that the schools were already using and was able to show the state Medicaid agency that the consolidated forms provided adequate documentation for claiming Medicaid. As a result, the district has achieved the required accountability along with some level of flexibility in how the information needed for Medicaid claims is presented.

[28]In its May 21, 1999, letter to state Medicaid directors, HCFA stated that soon it would no longer recognize bundled school-based health services as acceptable for purposes of claiming Medicaid federal funds. Subsequently, a work group was established to review bundling practices, and HCFA officials told us they plan to report on the results of this group's work in 2000. In the meantime, states with approved bundled rates have been allowed to continue this approach; however, the letter stated that states are expected to develop and implement a nonbundled reimbursement methodology within a "reasonable" amount of time.

- One school district in Vermont is currently operating a pilot program for processing its Medicaid claims and submitting them directly to the state agency's billing contractor. Officials told us that in the past, a school would submit claims to the state Department of Education, often waiting up to a year to receive reimbursement. Under the new pilot system, the Department of Education has agreed to reimburse schools within 1 month. In commenting on a draft of this report, a Vermont official told us that the state is adjusting its payment processes with the goal of making payments to all school districts within the month following the submission of claims.

Additional Federal Guidance Could Assist Coordination Efforts

Confusion over proper billing procedures, coupled with a lack of clear and consistent guidance from the federal government, has been a challenge to coordination in some states. Currently, HCFA's main guidance for claiming Medicaid reimbursement for school-based services is a technical assistance guide. The guide provides information regarding the specific Medicaid requirements associated with implementing a school health services program and seeking Medicaid funding for school health services and administrative activities.[29] However, officials of four states and two HCFA regional offices with whom we spoke believe that additional guidance is needed, including the need to identify (1) which services should be covered by Medicaid and which are educational in nature and (2) appropriate administrative cost claiming practices. Discussions with two Department of Education Regional Resource Center representatives reiterated states' interest in additional guidance.[30] Additionally, some Education officials we contacted believed that additional guidance from HCFA and Education would enhance coordination of Medicaid and IDEA.[31] HCFA has recognized the need for additional guidance, which it expects to issue sometime in 2000. Additionally, HCFA has established a position to advise the Administrator on disability policy and to perform other functions, such as facilitating communication among the Administrator of HCFA; other federal policymakers, including the Assistant Secretary for Special Education and Rehabilitation Services; and the disability community. The potential for changes in guidance on billing practices and

[29]See HCFA, Center for Medicaid and State Operations, Medicaid and School Health: A Technical Assistance Guide (Washington, D.C.: HHS, Aug. 1997).

[30]The Regional Resource Centers are funded by the Office of Special Education Programs and provide technical assistance services to state education agencies in the 50 states and in seven U.S. jurisdictions. The centers are funded specifically to help states improve programs and services for children and youth with disabilities, their families, and the professionals who serve them.

[31]Absent further federal guidance, one Regional Resource Center has developed a Medicaid work group aimed at providing the 10 states in its region with a network of shared information regarding Medicaid billing in schools. While only one meeting has been held to date, center representatives believe that this group will be a valuable forum for sharing information about claiming Medicaid funding for school-based and administrative services.

BEST COPY AVAILABLE

procedures will heighten the continuing need for additional efforts to coordinate the Medicaid and IDEA programs. For example, a state education official in New York told us that, after the May 21, 1999, policy changes from HCFA, it took a great deal of work to inform school districts, claims processors, and providers of the changes instituted and to train these entities to implement the changes. According to some of the state and local officials we contacted, such changes in reimbursement policies and procedures may also add to districts' concerns about relying on Medicaid funding. In fact, Florida education officials linked their concern to some Florida districts' decisions not to participate in Medicaid school-based billing. Additionally, one New York education official told us that schools that have been diligent in their Medicaid reimbursement efforts are particularly afraid of losing Medicaid revenue that has been built into their budgets. A Pennsylvania official revealed related worries, such as the fear of hiring new staff and initiating programs that are funded by a potentially uncertain financial source. Such perceptions, even if of limited validity, may further complicate and limit coordination between the two programs.

Conclusions

Coordination efforts between Medicaid and IDEA, particularly at the state and local levels, are complex and evolving. The varied nature of the states' Medicaid programs, coupled with the wide range of diversity among state and local education programs, requires that coordination efforts address broad federal requirements under what are often unique local and state circumstances. Interactions between IDEA and Medicaid also raise the challenge of balancing the need to provide children with the educational services necessary for their development and physical well-being against concerns that claims for Medicaid are inappropriate and excessive. Moreover, coordination efforts are currently being conducted in an environment in which federal guidance on Medicaid coverage for school-based services is unclear and inconsistent.

Both Medicaid and IDEA have an obligation to children with disabilities to ensure that they receive services that will best address their developmental needs, and coordination is essential to meeting this obligation. State and local efforts, however, require federal guidance to communicate Medicaid's coverage and documentation requirements. Without clear and consistent federal guidance, state and local entities run a greater risk of misunderstanding or misusing Medicaid as a funding source for school-based services. Recognizing this need, HCFA is developing additional guidance, which it expects to issue in the year 2000.

Agency and Other Comments

We provided officials from Education, HCFA, and the states and local school districts in our sample an opportunity to review a draft of this report. HCFA agreed that coordination efforts at the federal level could be improved. Education did not provide formal comments, but program officials offered several clarifications regarding coordination efforts with HCFA and discussions relevant to IDEA. HCFA expressed concern that our overall findings seemed to indicate that its guidance to states has been insufficient. HCFA also commented that it was unable to provide strict guidance given the variations in states' programs, and that coordination issues need to be resolved at the state and local levels, rather than at the federal/state level. While this report acknowledges the variety that exists in states' Medicaid and education programs, we agree that strict guidance is not an appropriate course. Nevertheless, state and HCFA officials both identified concerns that would benefit from additional federal direction. We further recognize that HCFA plans to provide additional guidance to states and school districts in an effort to provide additional direction in navigating this complex area. HCFA's written comments are provided in the appendix.

Education, HCFA, and responding state and local officials provided technical comments, which we incorporated as appropriate.

As agreed with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days from the date of this letter. At that time, we will send copies to the Honorable Donna Shalala, Secretary of Health and Human Services; the Honorable Nancy-Ann Min DeParle, HCFA Administrator; the Honorable Richard W. Riley, Secretary of Education; the Honorable Judith E. Heumann, Assistant Secretary, Office of Special Education and Rehabilitative Services, Department of Education; special education officials in the 12 states we contacted; and interested congressional committees. Copies will also be made available to others upon request.

If you or your staff have any questions about this report please call me at (202) 512-7118 or Carolyn Yocom at (202) 512-4931. Other staff who made contributions to this report were Laura Sutton Elsberg, JoAnn Martinez, Catina Bradley, and Behn Miller.

Sincerely yours,

Kathryn G. Allen

Kathryn G. Allen
Associate Director, Health Financing
and Public Health Issues

Contents

Letter 1

Appendix 24
Comments From the Health Care Financing Administration

Abbreviations

EPSDT	Early and Periodic Screening, Diagnostic and Treatment
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
IDEA	Individuals With Disabilities Education Act
IEP	individual education program
TPL	third-party liability

Comments From the Health Care Financing Administration

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

DATE: NOV 15 1999

TO: Kathryn G. Allen, Associate Director
Health Financing and Public Health Issues
General Accounting Office (GAO)

FROM: Nancy-Ann Min DeParle
Administrator

SUBJECT: GAO Draft Report, "Medicaid and IDEA: Additional Federal Guidance May Assist Coordination Efforts"

We appreciate the opportunity to review your draft report to Congress concerning the mechanisms of coordination between Medicaid and the Individuals with Disabilities Educational Act (IDEA). We are pleased by GAO's recognition that the Health Care Financing Administration is currently taking steps to address concerns identified in the report. However, we are concerned that the overall findings seem to indicate that HCFA has provided insufficient guidance to Medicaid agencies and schools on Medicaid coverage and billing requirements. HCFA is unable to provide strict guidelines to all of the states due to variations among state programs. Coordination issues need to be resolved at the state and local levels, rather than federal-state level.

In 1997, HCFA issued a Technical Assistance Guide (Guide) to assist states in implementing IDEA. The Guide was a comprehensive document that provided guidance regarding Medicaid requirements for coverage of, and billing for, school-based services. The Guide was very well received by state Medicaid agencies and the public, and is still being requested by interested parties. Nevertheless, HCFA recognized that the Medicaid and IDEA program coordination efforts could be improved and as noted in the report, we will issue additional guidance in the year 2000. On May 21, 1999, HCFA issued its first policy clarification letter to state Directors. This letter clarified the Medicaid payment policy with respect to transportation for IDEA children, and the use of the bundled payment methodology. Finally, HCFA established a task force to address issues of inconsistent oversight and to enhance coordination.

BEST COPY AVAILABLE

Page 2 - Kathryn G. Allen

This report should also note that the statute does not provide for exemptions from Medicaid requirements for medical services provided in schools. Schools must comply with all Medicaid rules relating to provider qualifications, covered services, and billing and audit requirements, in order to receive Medicaid reimbursement. While we recognize that schools may not be as well prepared or equipped to meet these requirements as traditional health care providers, HCFA's ability to provide flexibility to schools is limited. In addition, many managed care entities, the most common system for delivering Medicaid services, may not recognize school-based providers.

BEST COPY AVAILABLE

Ordering Information

The first copy of each GAO report and testimony is free. Additional copies are $2 each. Orders should be sent to the following address, accompanied by a check or money order made out to the Superintendent of Documents, when necessary. VISA and MasterCard credit cards are accepted, also. Orders for 100 or more copies to be mailed to a single address are discounted 25 percent.

Orders by mail:

U.S. General Accounting Office
P.O. Box 37050
Washington, DC 20013

or visit:

Room 1100
700 4th St. NW (corner of 4th and G Sts. NW)
U.S. General Accounting Office
Washington, DC

Orders may also be placed by calling (202) 512-6000 or by using fax number (202) 512-6061, or TDD (202) 512-2537.

Each day, GAO issues a list of newly available reports and testimony. To receive facsimile copies of the daily list or any list from the past 30 days, please call (202) 512-6000 using a touchtone phone. A recorded menu will provide information on how to obtain these lists.

For information on how to access GAO reports on the INTERNET, send an e-mail message with "info" in the body to:

info@www.gao.gov

or visit GAO's World Wide Web Home Page at:

http://www.gao.gov

United States
General Accounting Office
Washington, D.C. 20548-0001

Bulk Rate
Postage & Fees Paid
GAO
Permit No. G100

Official Business
Penalty for Private Use $300

Address Correction Requested